

BRAZORIA COUNTY VETERANS SERVICE OFFICE
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Sonya T. Broadway
Veteran Service Officer

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2022

Surviving Spouse:

Please find enclosed VA Form 21P-534EZ-Application for Dependency and Indemnity Compensation.
When you have gathered all necessary information on the enclosed checklist, please contact our office.

Respectfully,

Veteran Service Office
Brazoria County

Enclosures

***** PLEASE NOTE *****

The Brazoria County Veterans Service Office is a County Agency.

WE ARE NOT THE VA.

The (VA) Department of Veterans Affairs is a Federal Agency,
which has the POWER to Grant or Deny VA Claims.

Checklist to file DIC/Accrued- Brazoria County 2022:

- ____ Certified Copy of veterans DD214
- ____ Death Certificate of the Veteran
- ____ Copy of marriage certificate to the Veteran
- ____ Date and place of prior marriages of self and veteran
- ____ Date and place of dissolution of prior marriages of self and veteran
- ____ Are you currently expecting a child of the veteran? -yes or no
- ____ Your Date of Birth
- ____ Your Social Security Number
- ____ Home and Mailing address
- ____ Day & Evening telephone #
- ____ Best email address where your VA forms will be sent for your review and signature
- ____ Social Security Number of veteran if not on DD214
- ____ Full name of veteran
- ____ Date of Birth of Veteran
- ____ Place of Birth of veteran
- ____ Banking info for Direct Deposit Purposes-Name of Bank, Account Number, and Routing Number
- ____ Did veteran get Medical Care through VA? -If yes, what VA facility?

Dependency and Indemnity Compensation (DIC)-FOR THE SURVIVING SPOUSE

What is DIC?

DIC is a monthly benefit paid to eligible survivors of a

- Military service member who died while on active duty, active duty for training, or inactive duty training, OR
- Veteran whose death resulted from a service-connected injury or disease, OR
 - ✓ Veteran whose death resulted from a non service-connected injury or disease, and who were totally disabled from their service-connected disabilities for at least 10 years immediately preceding their death, OR
 - ✓ Since the veteran's release from active duty and for at least five years immediately preceding death, or
 - ✓ For at least one year immediately preceding death if the veteran was a former prisoner of war who died after September 30, 1999.

Who is Eligible?

The surviving spouse if he or she:

- Was married to a service member who died on active duty, active duty for training, or inactive duty training, OR
- Married the veteran before January 1, 1957 OR
- Married the veteran within 15 years of discharge from the period of military service in which the disease or injury that caused the veteran's death began or was aggravated, OR
- Was married to the veteran for at least one year, OR
- Had a child with the veteran, AND
- Cohabited with the veteran continuously until the veteran's death or, if separated, was not at fault for the separation, AND
- Is not currently remarried*

**May be eligible if you remarried on or after December 16, 2003, and were at least 57 years of age.*

The **surviving child** if he/she is the surviving child of a service member who died in the line of duty, or a veteran whose death resulted from a service-connected injury or disease. Additionally you must be:

- Unmarried AND
- Under age 18, or between the ages of 18 and 23 and attending school.

Note: *Certain helpless adult children are entitled to DIC.*

The Surviving parent(s) may be eligible for an income-based benefit.

How Much Does VA Pay?

The basic monthly rate of DIC is \$1,437.66 for an eligible surviving spouse. The rate is increased for each dependent child, also if the surviving spouse is housebound or in need of aid and attendance. VA also adds a transitional benefit of \$356.16 to the surviving spouse's monthly DIC if there are children under age 18. The amount is based on a family unit, not individual children. Benefit rate tables, including those for children alone and parents, can be found on the internet at http://benefits.va.gov/Compensation/current_rates_dic.asp

How Should a Claimant Apply?

Claimants should complete VA Form 21P-534EZ *Application for Dependency and Indemnity Compensation, Death Pension and Accrued Benefits by a Surviving Spouse or Child*.

What Are Some Related Benefits?

Health Care (CHAMPVA)
Home Loan Guaranty

Federal Employment Preference
Survivors' & Dependents' Educational Assistance

VETERAN'S SOCIAL SECURITY NUMBER -

18C. VETERAN ENTERED ACTIVE SERVICE ON (MM,DD,YYYY) Month Day Year 			18D. BRANCH OF SERVICE <div style="border: 1px solid black; height: 20px; width: 100%;"></div>			18E. RELEASE DATE FROM ACTIVE SERVICE (MM,DD,YYYY) Month Day Year 			
18F. PLACE OF LAST SEPARATION <div style="border: 1px solid black; height: 20px; width: 100%;"></div>									
19A. WAS THE VETERAN ACTIVATED TO FEDERAL ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. (National Guard)? <input type="radio"/> YES <input type="radio"/> NO (If "Yes," answer Items 19B, 19C and 19D)						19B. DATE OF ACTIVATION (MM,DD,YYYY) Month Day Year 			
19C. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT? <div style="border: 1px solid black; height: 30px; width: 100%;"></div>						19D. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>			
20A. WAS THE VETERAN EVER A PRISONER OF WAR? <input type="radio"/> YES <input type="radio"/> NO (If "Yes," complete Item 20B) (If "No," skip to Section III)					20B. DATES OF CONFINEMENT FROM: Month Day Year TO: Month Day Year 				
SECTION III- MARITAL INFORMATION (COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN) <i>(Skip to Section IV if you are NOT claiming benefits as the surviving spouse of the veteran)</i>									
TELL US ABOUT THE VETERAN'S MARRIAGES									
21A. HOW MANY TIMES WAS THE VETERAN MARRIED (including marriage to you)? <div style="border: 1px solid black; height: 20px; width: 100%;"></div>									
21B. DATE (month, day, year) and PLACE OF MARRIAGE (city, state or country) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		21C. TO WHOM MARRIED (first, middle, last name) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		21D. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		21E. HOW MARRIAGE ENDED (death, divorce) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		21F. DATE (month, day, year) and PLACE MARRIAGE ENDED (city/state or country) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
21G. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 21D, PLEASE EXPLAIN: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>									
TELL US ABOUT YOUR MARRIAGES									
22A. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN? <input type="radio"/> YES <input type="radio"/> NO					22B. HOW MANY TIMES HAVE YOU BEEN MARRIED? (including your marriage to the veteran) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>				
22C. DATE (month, day, year) and PLACE OF MARRIAGE (city/state or country) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		22D. TO WHOM MARRIED (first, middle, last name) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		22E. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		22F. HOW MARRIAGE ENDED (death, divorce, marriage has not ended) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		22G. DATE (month, day, year) and PLACE MARRIAGE ENDED (city/state or country) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
22H. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 22E, PLEASE EXPLAIN: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>									
23. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE? <input type="radio"/> YES <input type="radio"/> NO					24. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD? <input type="radio"/> YES <input type="radio"/> NO				
25. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF HIS/HER DEATH? <input type="radio"/> YES <input type="radio"/> NO (If "No," complete Item 26)					26. WHAT WAS THE CAUSE OF SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION (IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER) <div style="border: 1px solid black; height: 30px; width: 100%;"></div>				

VETERAN'S SOCIAL SECURITY NUMBER [] [] [] - [] [] [] - [] [] [] [] [] []

27. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID?

☐ YES ☐ NO (If "Yes," provide explanation):

SECTION IV: CHILD OF THE VETERAN (COMPLETE ONLY IF CLAIMING BENEFITS FOR A CHILD(REN) OF THE VETERAN)
(Skip to Section V if you are NOT claiming benefits for a child(ren) of the veteran) (If necessary, attach a separate sheet)

28A. NAME OF CHILD (First, middle initial, last name)	28B. DATE (month, day, year) and PLACE OF BIRTH (city/state or country)	28C. SOCIAL SECURITY NUMBER	(Check all that apply)						
			28D. BIOLOGICAL	28E. ADOPTED	28F. STEPCHILD	28G. 18-23 YEARS OLD (in school)	28H. SERIOUSLY DISABLED	28I. CHILD MARRIED	28J. CHILD PREVIOUSLY MARRIED
			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If claiming benefits as the surviving spouse or custodian filing for a child, in items 29A through 29D tell us about the children listed in Item 28A who **do not** live with you.

29A. NAME OF CHILD (First, middle initial, last name)	29B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country)	29C. NAME OF PERSON THE CHILD LIVES WITH (If applicable)	29D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
			\$
			\$
			\$

SECTION V: VETERAN'S PARENT (COMPLETE ONLY IF CLAIMING BENEFITS AS THE PARENT OF VETERAN)
(Skip to Section VI if you are NOT claiming benefits as the parent of a veteran)

30A. WHAT IS YOUR MARITAL STATUS? (Check one)

☐ MARRIED AND LIVE WITH OTHER PARENT OF VETERAN ☐ MARRIED AND LIVE WITH SPOUSE WHO IS NOT THE OTHER PARENT OF THE VETERAN ☐ SEPARATED, MARRIED BUT NOT LIVING WITH SPOUSE ☐ DIVORCED ☐ WIDOWED ☐ NEVER MARRIED

30B. IF YOUR MARRIAGE HAS ENDED, PLEASE SPECIFY THE DATE (month, day, year) AND HOW MARRIAGE ENDED (death, divorce, etc.)

30C. IF YOU ARE SEPARATED, WHAT WAS THE CAUSE OF THE SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION (IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)

31A. WHAT IS YOUR SPOUSE'S NAME? (First, middle initial, last name) (Skip to Item 32A if never married or no longer married)	31B. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? (MM,DD,YYYY)	31C. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER?
		[] [] [] - [] [] [] - [] [] [] [] [] []

31D. IS YOUR SPOUSE ALSO A VETERAN? <input type="radio"/> YES <input type="radio"/> NO (If "Yes," complete Item 31E)	31E. WHAT IS YOUR SPOUSE'S VA FILE NUMBER? (If applicable)
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32A. WAS THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF MAJORITY (AGE 18 IN MOST STATES)? <input type="radio"/> YES <input type="radio"/> NO (If "Yes," skip to Item 34)	32B. DATE(S) OF PARENTAL CONTROL (If veteran did not live in your household continuously before age 18 provide the time period (dates) when he/she was under your parental control) (MM DD YYYY) to (MM DD YYYY) (MM DD YYYY) to (MM DD YYYY)
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32C. WHY WASN'T THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF MAJORITY? (Explain fully)

VETERAN'S SOCIAL SECURITY NUMBER	—	—
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33. NAME AND ADDRESS OF EACH PERSON WHO ASSUMED PARENTAL CONTROL OVER THE VETERAN OUTSIDE THE DATE(S) SHOWN IN ITEM 32B			
A. NAME (FIRST, MIDDLE, LAST)		B. ADDRESS	
		Street address, rural route, or P.O. Box Apt. number	
		City	State ZIP Code Country
		Street address, rural route, or P.O. Box Apt. number	
		City	State ZIP Code Country
34. IF YOU ARE NOT THE BIOLOGICAL PARENT OF THE VETERAN, PROVIDE THE NAMES OF THE BIOLOGICAL PARENTS, IF DECEASED, PROVIDE THE DATE(S) OF DEATH.			
A. NAME (FIRST, MIDDLE, LAST)		B. DATE OF DEATH (MM,DD,YYYY)	

SECTION VI: DIC (COMPLETE ONLY IF CLAIMING DEPENDENCY AND INDEMNITY COMPENSATION (DIC))
(Skip to Section VII if you are NOT claiming DIC)

35. WHAT BENEFIT ARE YOU CLAIMING?

☐ DIC ☐ DIC under 38 U.S.C. 1151 (RARE)

36. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED TREATMENT PERTAINING TO YOUR CLAIM AND PROVIDE TREATMENT DATES:

A. NAME AND LOCATION OF VA MEDICAL CENTER	B. DATE(S) OF TREATMENT

SECTION VII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT

37. ARE YOU CLAIMING SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY DIC BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

(If "Yes," please complete and attach with this application, VA Form 21-2680, Exam for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS).)

☐ YES ☐ NO

38A. ARE YOU NOW IN A NURSING HOME?

☐ YES ☐ NO

(If "Yes," answer Items 38B and 38C. Also, submit a statement from an official of the nursing home that tells us that you are a patient in the nursing home because of a physical or mental disability. The statement should include the monthly charge you are paying out-of-pocket for your care.)

38B. WHAT IS THE NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY?

38C. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS?

☐ YES ☐ NO (If "No," complete Item 38D)

38D. HAVE YOU APPLIED FOR MEDICAID?

☐ YES ☐ NO

SECTION VIII: INCOME AND ASSETS (COMPLETE ONLY IF CLAIMING SURVIVORS PENSION OR PARENTS DIC)
(Skip to Section XI if you are NOT claiming survivors pension benefits or parents DIC)

IMPORTANT:

- IMPORTANT:**
- If you are a surviving spouse claimant, you must report income and assets for yourself and for any child of the veteran who lives with you or for whom you are responsible unless a court has decided you do not have custody of the child.
 - If you are a surviving child claimant (which means the child is not in the custody of a surviving spouse), you must report income and assets for yourself, your custodian, and your custodian's spouse.
 - If you are a surviving parent claimant, you must report income for yourself and your spouse.

39. DO YOU OR YOUR DEPENDENTS RECEIVE SOCIAL SECURITY BENEFITS?

☒ YES ☐ NO (If "YES," complete Item 40) (If "NO," skip to Item 41)

VETERAN'S SOCIAL SECURITY NUMBER -

40. GROSS MONTHLY INCOME (Attach a separate sheet if necessary)					
SOCIAL SECURITY RECIPIENT					GROSS MONTHLY AMOUNT
					\$
					\$
					\$
					\$
					\$
41. DO YOU OWN YOUR PRIMARY RESIDENCE? (Parents' DIC claimants skip to Item 43A)					
<input type="radio"/> YES <input type="radio"/> NO					
42A. WHAT IS THE SIZE OF THE LOT ON WHICH YOUR PRIMARY RESIDENCE SITS? (Square Feet)			42B. COULD PART OF YOUR LOT BE SOLD WITHOUT SELLING YOUR RESIDENCE?		
Square Feet: _____			<input type="radio"/> YES <input type="radio"/> NO (If "YES," complete and attach VA Form, 21P-0969, <i>Income and Asset Statement</i>)		
IMPORTANT: VA matches income information reported with Federal tax information. Report ALL income you and your dependents receive on the appropriate sections of this form and VA Form 21P-0969, <i>Income and Asset Statement</i> , if appropriate.					
43A. OTHER THAN SOCIAL SECURITY, DO YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME?			43B. OTHER THAN SOCIAL SECURITY, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR?		
<input type="radio"/> YES <input type="radio"/> NO			<input type="radio"/> YES <input type="radio"/> NO		
43C. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN \$10,000 IN ASSETS? (NOTE: Assets are all the money and property you or your dependents own. Assets <i>do not</i> include your primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation)					
<input type="radio"/> YES <input type="radio"/> NO					
43D. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Examples of asset transfers include giving them away, selling them, purchasing an annuity, or using them to establish a trust)					
<input type="radio"/> YES <input type="radio"/> NO					
43E. DID YOU ANSWER "YES," TO ANY OF THE QUESTIONS IN ITEMS 43A THRU 43D?					
<input type="radio"/> YES <input type="radio"/> NO (If "Yes," you <i>must</i> also complete VA Form 21P-0969, <i>Income and Asset Statement</i>)					
SECTION IX: INFORMATION ABOUT YOUR MEDICAL OR OTHER EXPENSES					
Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts you paid for the last illness and burial of a spouse or child. Educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you were/will be reimbursed. Please make sure to complete all 6 criteria below (if applicable). If you need more space, complete and attach a separate VA Form 21P-8416, <i>Medical Expense Report</i> .					
IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet on pages 13 and 14.					
44. ARE YOU CLAIMING UNREIMBURSED MEDICAL EXPENSES?					
<input type="radio"/> YES <input type="radio"/> NO (If "No," skip to Section X)					
45A. WHOSE MEDICAL, LEGAL, OR OTHER EXPENSES WERE PAID?	45B. PAID TO (Name of provider, insurance company, nursing home, etc.)	45C. PURPOSE (Medicare premiums, nursing home, etc.)	45D. DATE PAID (MM,DD,YYYY)	45E. HOURLY RATE/HOURS (In-home Provider only)	45F. AMOUNT YOU PAY

VETERAN'S SOCIAL SECURITY NUMBER - -

CONTINUED

[illegible]**SECTION X: DIRECT DEPOSIT INFORMATION (MUST COMPLETE)**

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, and attach either a voided personal check or a deposit slip. If you **do not** have a bank account, please visit <https://www.benefits.va.gov/benefits/banking.asp>. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

46. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)

○ CHECKING

○ SAVINGS

☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No.: _____ Account No.: _____

47. NAME OF FINANCIAL INSTITUTION
(where you want your direct deposit)

48. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

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SECTION XI: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE)

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled *Notice to Survivor of Evidence Necessary to Substantiate a Claim for Dependency Indemnity Compensation, Death Pension, and/or Accrued Benefits*.

I certify I have enclosed all information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR**, I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 49, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

49. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will *automatically* consider a claim submitted on this form for rapid processing under the FDC Program. Check the box below **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

☐ I **DO NOT** want my claim considered for rapid processing under the FDC Program because I plan to submit further evidence in support of my claim.

50A. CLAIMANT'S SIGNATURE (REQUIRED)

50B. DATE SIGNED

SECTION XII: WITNESSES TO SIGNATURE (COMPLETE ONLY IF CLAIMANT SIGNED ITEM 50A WITH AN "X")

51A. SIGNATURE OF WITNESS (If claimant signed above using an "X")

51B. PRINTED NAME AND ADDRESS OF WITNESS

52A. SIGNATURE OF WITNESS (If claimant signed above using an "X")

52B. PRINTED NAME AND ADDRESS OF WITNESS

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation and/or pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.